Filing at a Glance

Company:	Vision Service Plan Insurance Company
Product Name:	Individual Vision Care Policy
State:	District of Columbia
TOI:	H20I Individual Health - Vision
Sub-TOI:	H20I.000 Health - Vision
Filing Type:	Form
Date Submitted:	12/13/2019
SERFF Tr Num:	VSPN-132154892
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	IP VARIABLE FILING
Implementation Date Requested:	On Approval
Author(s):	Melissa Harris
Reviewer(s):	Colin Johnson (primary), RaShaunda Benson
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: District of Columbia **Filing Company:** Vision Service Plan Insurance Company
TOI/Sub-TOI: H20I Individual Health - Vision/H20I.000 Health - Vision
Product Name: Individual Vision Care Policy
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Melissa Harris

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 12/17/2019
State Status Changed:
Created By: Melissa Harris
Corresponding Filing Tracking Number: VSPN-132165946

Filing Description:

Re: Initial Form-Vision Service Plan Insurance Company (“VSP”) /NAIC# 39616

Dear Sir or Madam:

Please find attached for review and formal approval, an initial form filing on behalf of Vision Service Plan Insurance Company (“VSP”), a District of Columbia accident and health carrier. The policy form included in this filing is new and will not be replacing previously approved forms. The Policy, “VSP IND DC 1119,” is an individual plan of vision care providing benefits for an optometric examination, spectacle frames and lenses and contact lenses. This Policy is different from previously approved forms because it includes a wider range of covered benefits and includes the option for the insured to purchase additional benefit riders.

Rates have been filed separately under SERFF Tracking#VSPN-132165946.

Please do not hesitate to contact me with questions. I may be reached at (916) 858-5217 or by email at meliha@vsp.com.

Sincerely,

Melissa Harris
meliha@vsp.com
(916) 858-5217

Company and Contact

Filing Contact Information

Melissa Harris,
3333 Quality Drive (MS163)
Rancho Cordova, CA 95670

meliha@vsp.com
916-858-5217 [Phone]

State: *District of Columbia* ***Filing Company:*** *Vision Service Plan Insurance Company*
TOI/Sub-TOI: *H20I Individual Health - Vision/H20I.000 Health - Vision*
Product Name: *Individual Vision Care Policy*
Project Name/Number: */*

Filing Company Information

Vision Service Plan Insurance Company
3333 Quality Drive
(MS163)
Rancho Cordova, CA 95670
(916) 851-4898 ext. [Phone]

CoCode: 39616
Group Code: 1189
Group Name: Vision Service Plan
FEIN Number: 06-1227840

State of Domicile: Ohio
Company Type: Accident and Health
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*VSPN-132154892*	***State Tracking #:***		***Company Tracking #:***	*IP VARIABLE FILING*

State:	*District of Columbia*	***Filing Company:***	*Vision Service Plan Insurance Company*
TOI/Sub-TOI:	*H20I Individual Health - Vision/H20I.000 Health - Vision*		
Product Name:	*Individual Vision Care Policy*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Vision Care Policy	VSP IND DC 1119	POL	Initial			Policy.pdf
2		Computer Visioncare Plan	CVC Rider DC 1119	POLA	Initial			CVC.Rider.pdf
3		ProTec Safety	ProTec Rider DC 1119	POLA	Initial			ProTec Rider.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

VISION SERVICE PLAN INSURANCE COMPANY

LIMITED BENEFIT, PLEASE READ CAREFULLY

INDIVIDUAL VISION CARE POLICY

TABLE OF CONTENTS

[Insert if Policyholder has purchased Additional Benefits

ATTACHMENT(S)

INDIVIDUAL VISION CARE POLICY

Provided By

Vision Service Plan Insurance Company

POLICY NUMBER:

POLICYHOLDER'S NAME:

COVERED DEPENDENTS:

POLICY EFFECTIVE DATE:

PREMIUM: $ [ ] per Plan Term

STATE OF DELIVERY: District of Columbia

You, the Policyholder under this Policy, shall be permitted to return this Policy within ten (10) days of its delivery to You and to have the premium paid refunded if, after examination of the Policy, You are not satisfied with it for any reason. If You return this Policy, as described above, to Vision Service Plan Insurance Company ("VSP") at its home office, it shall be void from the beginning. This means that You will be responsible for payment in full of any services received or materials purchased from the Policy Effective Date to the date the Policy is voided. If this Policy is so voided, VSP will not be liable for payment of any Plan Benefits utilized by any Covered Person under this Policy.

The benefits available under this Policy are provided by Vision Service Plan Insurance Company ("VSP"). For any questions or problems concerning any provisions of this Plan, please contact VSP at (800) 877-7195 or in writing to 3333 Quality Drive, Rancho Cordova, CA 95670.

REQUIRED PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy, and all riders, endorsements, exhibits and any other attached papers constitute the entire contract of insurance. A change in this Policy is not valid until the change is approved by an executive officer of VSP and unless the approval is endorsed on or attached to this Policy. A broker or other agent does not have authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by You in the application for this Policy shall be used to void this Policy or to deny a claim for a loss incurred, as defined in this Policy, commencing after the expiration of such two-year period.

GRACE PERIOD

Unless, not less than thirty (30) days prior to the premium due date VSP has delivered to the Policyholder, or has mailed to the Policyholder's last address as shown by VSP's records, written notice of its intention not to renew this Policy beyond the period for which the premium has been accepted, a grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium.

REINSTATEMENT

If a renewal premium is not paid before the expiration of the period granted for the Policyholder to make the payment, a subsequent acceptance of the premium by VSP or any agent authorized by VSP to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the Policy. However, if VSP or its authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated on approval of the application by VSP or, if the application is not approved, on the 45th day after the date of the conditional receipt unless VSP before that date has notified the Policyholder in writing of VSP's disapproval of the application. The Policyholder and VSP have the same rights under the reinstated Policy as they had under the Policy before the due date of the defaulted premium, subject to any provisions endorsed in the Policy or attached to the Policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not previously been paid, but not to any period more than sixty (60) days before the date of reinstatement.

LEGAL ACTION

No civil action shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

RENEWABILITY

This Policy is renewable at the option of the Policyholder so long as premiums are paid in a timely manner, the Policyholder has not performed an act or practice that constitutes fraud and VSP continues to offer this plan in the District of Columbia].

DEFINITIONS OF WORDS AND PHRASES USED IN THIS POLICY

Additional Benefit Rider	The document, attached as Exhibit A to this Policy (when purchased by Policyholder), which lists selected vision care services and/or vision care materials which a Covered Person is entitled to receive under this Policy.
Benefit Authorization	Authorization from VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which Covered Person is entitled at the time the authorization is issued.
Copayment	An amount required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
Covered Dependent	A Policyholder's eligible dependent who is covered under this Policy.
Covered Person	A person insured under this Policy, including the Policyholder and any Covered Dependent.
Open Access Provider	Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
Plan or Plan Benefits	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Policy.
Plan Term	A twelve (12) month period beginning on the Plan Effective Date of this Policy and on each subsequent anniversary thereof.
Policy	This document and all of its attachments, if any.
Policyholder	The person who signed the application for this Policy and who is responsible for payment of premiums for this Policy.
You, Your	The person insured under this Policy. The Policyholder.
VSP Preferred Provider	An optometrist or ophthalmologist, licensed and otherwise qualified to practice vision care and/or provide vision care materials, who has contracted with VSP to provide Plan Benefits on behalf of Covered Persons of VSP.

We, Us, Our, VSP This refers to Vision Service Plan Insurance Company.

PLAN BENEFITS

During each Plan Term the following vision care services and/or materials are available to Covered Persons under this Policy, and when purchased by Policyholder, the Additional Benefit Rider(s) attached hereto, subject to any limitations, exclusions, or Copayments therein stated.

[Examination

Each Plan Term, You and each of Your Covered Dependents are entitled to one complete initial vision analysis which will include an examination of visual functions and prescription of corrective eyewear where needed. At the time of the examination, You will be responsible for paying the VSP Preferred Provider a Copayment of $ [0-$20.00]. You will not be responsible for any other charges relating to the examination.]

[Lenses*

Each Plan Term, You and each of Your Covered Dependents are entitled to receive one pair of prescription lenses. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Preferred Provider 1), the following Copayment† and 2), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limitations".

[For Lenses, no Copayment is required.]
[For Lenses, a Copayment of $ [0-$30.00].]
[For Single Vision Lenses, a Copayment of $[0-$30.00].]
[For Bifocal Lenses, a Copayment of $[0-$30.00].]
[For Trifocal Lenses, a Copayment of $[0-$30.00].]
[For Lenticular Lenses, a Copayment of $[0-$30.00].]

[Additionally, You and each of Your Covered Dependents are entitled to include the following Lens Options with Your Lens benefit:

[*Insert Lens Options purchased by Member*

[For Progressive Lenses, a Copayment of $ [0-$55.00].]
[For Polycarbonate Lenses, a Copayment of $ [0-$15.00].]
[For Transitions Lenses, a Copayment of $ [0-$40.00].]
[For Anti-reflective Coating, a Copayment of $ [0-$40.00].]
[For Photochromic Lenses, a Copayment of $ [0-$40.00].]
[For Scratch Coating, a Copayment of $ [0-$30.00].]
[For UV Coating, a Copayment of $ [0-$30.00].]
[For Tinted Lenses, a Copayment of $ [0-$30.00].]
[For Polarized Lenses, a Copayment of $ [0-$20.00].]
[For High Index Lenses, a Copayment of $ [0-$30.00].]

[Frames*

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the purchase of one set of frames. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-$30.00]† 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limitations".

Your Plan Benefits for frames and lenses shall also include necessary professional services such as prescribing and ordering proper lenses, assisting in frame selection, verifying accuracy of finished lenses, proper fitting and adjustments of frames, subsequent adjustments to frames to maintain comfort and efficiency and progress or follow-up work as necessary.

[Frame Allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.]

† If both frames and lenses are purchased separately during a single Plan Term, the $ [0-$30.00] Copayment will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Term, only one $ [0-$30.00] Copayment will be required for the combined purchase.]

[Contact Lenses*

Each Plan Term You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. For each pair of extended wear contact lenses or for each supply of disposable contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), any amounts which exceed Your Plan allowance, and 2), any charges for services and/or materials not covered under this Policy. For a list of non-covered services and materials, please refer to the section entitled "Plan Limitations".]

[*Important: Under this Policy, [each Plan Term] You and each of Your Covered Dependents may purchase either 1) one pair of prescription eyeglasses (frame and lenses), or 2), one pair of extended wear contact lenses or a supply of disposable contact lenses.]

[*Insert as appropriate to the Plan Benefits selected by Policyholder:*

[Contact Lens Fitting and Evaluation Exam

Each Plan Term, You and each of Your Covered Dependents are entitled to exam specific to contact lenses for fitting and evaluation. At the time of the examination, You will be responsible for paying the VSP Preferred Provider a Copayment of $ [0-$20.00]. You will not be responsible for any other charges relating to the examination.]

[SunCare Non-Prescription Frame Allowance

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the purchase of one set of nonprescription sunglasses. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-$30.00]† 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. Lab-fabricated plano lenses are not covered.]

[Second Pair

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $[95.00-$300.00] toward an additional pair of frames and prescription lenses or contact lenses subject to any conditions, limitations and/or exclusions stated in this Policy. For each additional pair of frames and prescription lenses or contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-$30.00]† 2), any costs for the purchase which exceed Your plan allowance and 3), any charges for materials not covered under this Policy.

[Covered Contact Lenses

Each Plan Term You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-$300.00] toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. For each pair of extended wear contact lenses or for each supply of disposable contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0.00-$50.00] 2), any amounts which exceed Your Plan allowance, and 2), any charges for services and/or materials not covered under this Policy. For a list of non-covered services and materials, please refer to the section entitled "Plan Limitations".]

[OTHER PLAN BENEFITS

You and each of Your Covered Dependents are also entitled to receive the additional vision care services as stated below.

Additional Discount

In addition to the specific Plan Benefits stated above, You and each of Your Covered Dependents are entitled to receive a discount of twenty percent (20%) toward the purchase of additional complete pairs of prescription glasses (frames, lenses and Lens Options) from VSP Preferred Providers. Additional pairs are those purchased beyond the Plan Term benefit frequency allowed under this Policy.

You will be responsible for paying the VSP Preferred Provider the balance of any charges for materials and services after the applicable discount(s) are applied. To receive the discount(s), all services and/or materials must be purchased within twelve (12) months of an examination covered under this Policy and must be purchased from a VSP Preferred Provider.

Important: Additional Discounts do not apply to vision care services and/or materials obtained from an Open Access Provider.]

WHAT YOU NEED TO KNOW ABOUT USING YOUR PLAN BENEFITS

How to obtain services and materials under this Policy

When You or any of Your Covered Dependents want to receive Plan Benefits, contact a VSP Preferred Provider and make an appointment. Identify Yourself as a VSP insured and the VSP Preferred Provider will contact VSP to verify Your eligibility and obtain a Benefit Authorization. You should refer to the VSP List of VSP Preferred Providers provided to You with Your Policy for the names of the VSP Preferred Providers in Your area. You may also find the locations of VSP Preferred Providers by visiting VSP's web site at www.vsp.com or by calling VSP Customer Care toll-free at (800) 877-7195. Covered Persons are not limited to any geographic area when they wish to use Plan Benefits. They may select and utilize a VSP Preferred Provider anywhere throughout the United States.

Why a Benefit Authorization is required

A Benefit Authorization is VSP's way of confirming to You and to the VSP Preferred Provider that You and Your Covered Dependents are eligible to receive Plan Benefits. If You or a Covered Dependent receive Plan Benefits without a Benefit Authorization, You would be responsible for paying the full amount of the services and/or materials to the doctor. If You cancel and return this Policy within ten (10) days of purchase, You will be responsible for payment of all expenses incurred by You or Your Covered Dependents for services or materials, even if VSP had issued a Benefit Authorization.

Plan Benefits received from an Open Access Provider

You and Your Covered Dependents may receive Plan Benefits from any duly licensed optometrist or ophthalmologist. If You or Your Covered Dependents receive Plan Benefits from an Open Access Provider, You will be responsible for paying the provider's full fee and requesting reimbursement from VSP. The amount reimbursed to You by VSP may not be enough to cover the full amount of the Open Access Provider's fee. VSP Preferred Providers have agreed to accept discounted fees for their services and to not bill You for Plan Benefits payable under this Policy. Open Access Providers do not have such an agreement with VSP and can charge You their full, non-discounted fees. Also, VSP is unable to require Open Access Providers to adhere to VSP's quality standards. Plan Benefits received from an Open Access Provider will exhaust Covered Persons' Plan Benefits under this Policy. Covered Persons may not receive similar Plan Benefits from both a VSP Preferred Provider and an Open Access Provider. For example, if We pay for an exam from a VSP Preferred Provider, no Plan Benefits will be available for an exam from an Open Access Provider.

Emergency services

Plan Benefits provided by VSP under this Policy are for routine vison care services and materials only. This Policy does not cover treatment for medical conditions, whether due to an emergency or to any other cause. If You or any of Your Covered Dependents require medical treatment for any reason, You should contact a medical provider.

Your rights under this Policy if You have problems or questions

For any questions You may have regarding Your coverage under this Policy, please contact VSP's Customer Care Division at (800) 877-7195, Monday through Friday, from 6 AM to 7 PM, Pacific Time. Many of Your questions may also be answered by visiting VSP's web site at www.vsp.com.

If You should ever have a complaint about the quality of the care You receive from a VSP Preferred Provider, wish to request reconsideration from VSP of a claim denied for payment, or for any other matter, Your first step should be to contact VSP's Customer Care Division. If they are not able to resolve Your complaint, they will assist You in the procedures for pursuing a formal review of Your concerns by VSP. For additional information on this matter, please refer to the section entitled "How VSP handles payment of claims".

HOW VSP HANDLES PAYMENT OF CLAIMS

Plan Benefits under this Policy are underwritten by Vision Service Plan Insurance Company, and are subject to preferred provider arrangements.

A preferred provider, referred to in this Policy as a "VSP Preferred Provider", is an optometrist or ophthalmologist that has signed a contract with VSP to provide Plan Benefits to Covered Persons under VSP policies. Each VSP Preferred Provider has agreed to accept discounted fees as payment from VSP in exchange for being listed in VSP's directory of its contracting doctors. A doctor who is not a preferred provider has no contractual arrangement with VSP and can charge whatever fee he or she desires. You can obtain more information regarding VSP's preferred providers, including a list of doctors in Your area, by visiting VSP's web site at www.vsp.com, by calling VSP's Customer Care Division at (800) 877-7195 or by writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

Services from VSP Preferred Providers

When You or Your Covered Dependents receive services or materials from a VSP Preferred Provider, the doctor will submit any required claims directly to VSP. VSP will then pay the doctor for the Plan Benefits You or Your Covered Dependents received. You will never be required to file a claim with VSP. If VSP fails to pay the VSP Preferred Provider, neither You nor any of Your Covered Dependents will be held liable for any sums owed by VSP other than those not covered by VSP under this Policy.

Services from Open Access Providers

When You or Your Covered Dependents receive services or materials from an Open Access Provider, You will usually be required by the provider to pay the charges in full. You would then need to submit a claim form, along with copies of any invoices or receipts received from the doctor for the services or materials, to VSP for reimbursement. You may obtain a claim form on vsp.com or by calling (800) 877-7195. Claim forms may be submitted at vsp.com or at the address below:

VSP
Attn: Claims Processing
P. O. Box 385018
Birmingham, AL 35238-5018

You will be reimbursed for the services or materials based on the following Open Access Provider Schedule of Allowances and the reimbursement schedule shown on the attached Additional Benefit Rider(s) if purchased by Policyholder, less any applicable Copayments.

Open Access Provider Schedule of Allowances	
Service or Material	**Allowance**
[Examination	$ 45.00]
[Single Vision Lens (pair)	$ 30.00]
[Bifocal Lens (pair)	$ 50.00]
[Trifocal Lens (pair)	$ 65.00]
[Progressive Lens (pair)	$ 50.00]
[Lenticular Lens (pair)	$ 100.00]
[Frame	$ 70.00]
[Contact Lens (pair)	$ 105.00]

(This schedule is updated annually on January 1st of each year. When updated, allowances may change from those stated above.)

Claim Forms

VSP does not require notice of claim. You may obtain a claim form on vsp.com or call (800) 877-7195 to request a hard copy. VSP will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If the forms are not furnished within ten working days after such request, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of loss

For reimbursement of any loss under this Policy, proof of loss must be provided to VSP at vsp.com or at the address stated above no more than three hundred sixty-five (365) calendar days after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise requried, except in the event of legal incapacity.

Under the provisions of this Policy, "loss" means any amounts You paid for services or materials to an Open Access Provider. A "proof of loss" means a request for reimbursement as described in the "Services from Open Access providers" section, above. "Date of loss" means the date services were rendered or materials purchased.

Time of payment of claims

Requests for reimbursement payable under this Policy will be paid or denied within fifteen (15) calendar days of receipt of a request for reimbursement as described in the section entitled "Services from Open Access Providers", above. Requests for reimbursement received by VSP which are not complete may result in a delay in payment. If VSP requires additional information in order to process Your claim, We will contact You by telephone or in writing within fifteen (15) calendar days after receipt of Your request for reimbursement. Once all requested information has been received, We will pay or deny Your claim within fifteen (15) calendar days.

Payment of claims

If any amounts payable for Plan Benefits under this Policy shall be payable to the estate of the Policyholder, or to a Policyholder or beneficiary who is a minor or otherwise not competent to give a valid release, VSP may pay such amounts to any relative by blood or connection by marriage of the Policyholder or beneficiary who is deemed by VSP to be equitably entitled thereto. Any payment made by VSP in good faith pursuant to this provision shall fully discharge VSP to the extent of such payment.

Other insurance coverage

VSP will not coordinate Plan Benefits payable under this Policy with any other private or government insurance plan, including any other plan underwritten by VSP.

Denial of payment for claims

If VSP denies a claim, You have the right to request a reconsideration of the denial. Also, if VSP denies Your request for reconsideration of the claim, You have the right to appeal this decision.

You may obtain more information concerning VSP's appeals process by contacting VSP's Customer Care Division at (800) 877-7195.

PLAN LIMITATIONS

[Insert if Member did not purchase Lens Options benefit:
PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. If You or any of Your Covered Dependents obtain lens enhancements such as (but not limited to) blended lenses, tinted lenses, lens coatings, or any other "Lens Options" not related to the correction of refractive error, VSP will pay the amount stated in the Plan Benefits section for the lenses and You will be responsible for paying the VSP Preferred Provider for the additional costs of the Lens Options.]

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Preferred Provider or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

The following services and/or materials are not covered under this Policy.

1. Services and/or materials not included as Plan Benefits in this Policy.
2. Orthoptics or vision training and any associated supplemental testing.
3. Corneal Refractive Therapy (CRT)
4. Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
5. Refitting of contact lenses after the initial (90-day) fitting period.
6. Plano lenses (lenses with refractive correction equal to or less than ± .50 diopter) or contact lenses.
7. Two pair of glasses in lieu of bifocals.
8. Replacement of lenses and frames or contact lenses furnished under this Policy which are lost or broken, except at the normal intervals when Plan Benefits are otherwise available.
9. Medical or surgical treatment of the eyes.
10. Plano contact lenses to change eye color cosmetically.
11. Contact lenses used to change eye color cosmetically or artistically painted lenses.
12. Contact lens insurance policies or service contracts.
13. Additional office visits associated with contact lens pathology.
14. Contact lens modification, polishing or cleaning.
15. Costs for services and/or materials exceeding Plan Benefit allowances.
16. Services or materials of a cosmetic nature.
17. Local, state and/or federal taxes, except where VSP is required by law to pay.

EXHIBIT A

ADDITIONAL BENEFIT RIDER
COMPUTER VISIONCARE PLAN

GENERAL

This Rider lists the vision care services to which Covered Persons of Vision Service Plan Insurance Company ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Policy to which it is attached. This Rider forms a part of the Policy to which it is attached.

ELIGIBILITY

COVERED PERSONS WHO UTILIZE A COMPUTER MONITOR AND/OR DIGITAL MEDIA SHALL BE ELIGIBLE FOR THE COMPUTER VISIONCARE (CVC) PLAN.

Covered Persons are eligible for CVC Plan Benefits if they have been diagnosed by an eye care professional as having a vision condition affecting computer and/or digital media use.

PLAN BENEFITS

COPAYMENT

There shall be a $25.00 Copayment payable at the time the materials are ordered.

COVERED SERVICES AND MATERIALS

SUPPLEMENTAL EYE EXAMINATION: Covered in full* once every 12 **months****
A Limited Level supplemental vision analysis of the eyes and related structures which addresses the specific visual needs relative to computer and/or digital media eyewear.

LENSES: Covered in full* once every 12 **months**
Spectacle Lenses (Single, Lined Bifocal, Lined Trifocal. Specific Near Variable Focus and Occupational Progressives lenses specifically designed for working on a computer and/or digital media in glass/plastic materials)

FRAMES: Covered up to $ [plan allowance]*** once every** 12 **months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, will verify the accuracy of finished lenses, and will assist Covered Person with frame selection and adjustment.

Associated Vision Therapy (specific to Computer and/or digital media use): Covered up to $200.00 per year once every 12 **months.**

Includes any supplemental testing with treatment.

Plan Benefits for Vision Therapy are limited to Covered Persons who are eligible for CVC coverage and who are diagnosed as having one of the following conditions:

Accommodative Insufficiency: The inability to change focus quickly when looking from one distance to another or the inability to maintain focus at one distance for a prolonged period of time. (Primarily when looking at objects up close.)

Convergence Insufficiency: The eye muscles' inability to point the eye straight when working up close.

Accommodative Spasm: a condition that causes the eye muscle to accommodate or focus constantly and automatically.

*Less any applicable Copayment.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Preferred Provider or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Everyday eyewear glasses instead of computer glasses
2. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
3. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
4. Non-covered lens enhancements (example: Clip-on lenses, Sunglasses)
5. Two pair of glasses instead of bifocals.
6. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when Plan Benefits are otherwise available.
7. Orthoptics or vision training and any associated supplementary testing not specifically related to working with a computer and/or digital media.
8. Medical or surgical treatment of the eyes.
9. Contact lenses.
10. Laminated lenses or tints greater than 20%.
11. Coordination of benefits (e.g., CVC coverage may not be used to cover extras from other plans and other VSP plans may not be used to cover CVC extras)
12. The patient must be eligible for lenses to obtain materials.
13. If the patient cannot adjust to the occupational progressive lens, benefits will not be reinstated. Payment becomes a private transaction between the patient and the doctor.
14. Patients qualify for CVC materials only if the prescription differs by ±0.50 diopters from glasses prescribed for every day use. Materials should be designed to be worn for computer and/or digital media use only.
15. Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

Open Access Provider Schedule of Allowances	
Service or Material	**Allowance**
Single Vision Lens (pair)	$ 10.00
Bifocal Lens (pair)	$ 45.00
Trifocal Lens (pair)	$ 60.00
Progressive Lens (pair)	$ 45.00
Lenticular Lens (pair)	$ 100.00
Frame	$ 45.00

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also be applicable to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

ADDITIONAL BENEFIT RIDER
ProTec Safety®

GENERAL

This Rider lists additional vision care services and materials to which Covered Persons of *Vision Service Plan Insurance Company* ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or on the Policy to which it is attached. This Rider forms a part of the Policy to which it is attached.

ELIGIBILITY

COVERED PERSONS WHO REQUIRE SAFETY EYEWEAR DUE TO THE NATURE OF THEIR WORK SHALL BE ELIGIBLE FOR THE PROTEC SAFETY PLAN.

PLAN BENEFITS

COPAYMENT

[There shall be a $ [5.00-$25.00] Copayment payable at the time the materials are ordered. *Or*

There shall be no Copayment payable by Covered Person under this plan.]

COVERED SERVICES AND MATERIALS

LENSES- Covered in full* once every 12 months.
VSP Preferred Providers shall ensure that lenses provided under ProTec Safety meet all current standards established by the American National Standards Institute (ANSI).

PROTEC EYEWEAR® FRAMES† - Covered in full* once every 12 months.
VSP Preferred Providers shall ensure that frames provided under ProTec Safety meet all current ANSI standards.

*Less any applicable Copayment.
†Frames available under ProTec Safety are those included in the ProTec Safety Eyewear frame kit. Should Covered Person choose a frame outside of the ProTec Eyewear frame kit, Covered Person may incur out-of-pocket expenses.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame or lens brand availability from their VSP Preferred Provider or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
3. Two pair of glasses instead of bifocals.
4. Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Contact lenses.
8. Replacement of lost or damaged contact lenses.
9. Refitting of contact lenses.
10. Additional office visits associated with contact lens pathology.
11. Everyday eyewear lenses instead of safety materials.

12. Eye examinations.
13. Local, state and/or federal taxes, except where VSP is required by law to pay.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

Open Access Provider Schedule of Allowances	
Service or Material	**Allowance**
Single Vision Lens (pair)	$ 35.00
Bifocal Lens (pair)	$ 45.00
Trifocal Lens (pair)	$ 60.00
Progressive Lens (pair)	$45.00
Lenticular Lens (pair)	$ 90.00
Frame	$ 25.00

EXCLUSIONS AND LIMITATIONS OF BENEFITS
OPEN ACCESS PROVIDERS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards or to ensure that lenses and frames secured from Open Access Providers adhere to ANSI standards.
5. Open Access Providers do not have access to the ProTec Eyewear® frame kit.

SERFF Tracking #:	*VSPN-132154892*	***State Tracking #:***		***Company Tracking #:***	*IP VARIABLE FILING*

State:	*District of Columbia*	***Filing Company:***	*Vision Service Plan Insurance Company*
TOI/Sub-TOI:	*H20I Individual Health - Vision/H20I.000 Health - Vision*		
Product Name:	*Individual Vision Care Policy*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	StatementVariability.pdf
Item Status:	
Status Date:	

STATEMENT OF VARIABILITY

Vision Service Plan Insurance Company

INDIVIDUAL VISION CARE POLICY (VSP IND DC 1119)

1. Page 1, *[*ATTACHMENT(S)
   EXHIBIT A – ADDITIONAL BENEFIT RIDER(S) [ProTec Safety][and][Computer Visioncare Plan]…….XX]

   This information will be included if policyholder purchases additional benefit riders.

2. Page 4,

   [Examination

   Each Plan Term, You and each of Your Covered Dependents are entitled to one complete initial vision analysis which will include an examination of visual functions and prescription of corrective eyewear where needed. At the time of the examination, You will be responsible for paying the VSP Preferred Provider a Copayment of $ [0-$20.00]. You will not be responsible for any other charges relating to the examination.]

   This language will be included when examination coverage is purchased by the policyholder.

3. Page 4,

   [Lenses*

   Each Plan Term, You and each of Your Covered Dependents are entitled to receive one pair of prescription lenses. For each pair of lenses You and Your dependents receive You will be responsible for paying the VSP Preferred Provider 1), the following Copayment† and 2), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limitations".

   [For Lenses, no Copayment is required.]
   [For Lenses, a Copayment of $ [0-$30.00].]
   [For Single Vision Lenses, a Copayment of $[0-$30.00].]
   [For Bifocal Lenses, a Copayment of $[0-$30.00].]
   [For Trifocal Lenses, a Copayment of $[0-$30.00].]
   [For Lenticular Lenses, a Copayment of $[0-$30.00].]

   This language will be included when lenses coverage is purchased by the policyholder.

4. Page 4,

[Additionally, You and each of Your Covered Dependents are entitled to include the following Lens Options with Your Lens benefit:

[For Progressive Lenses, a Copayment of $ [0-$55.00].]
[For Polycarbonate Lenses, a Copayment of $ [0-$15.00].]
[For Transitions Lenses, a Copayment of $ [0-$40.00].]
[For Anti-reflective Coating, a Copayment of $ [0-$40.00].]
[For Photochromic Lenses, a Copayment of $ [0-$40.00].]
[For Scratch Coating, a Copayment of $ [0-$30.00].]
[For UV Coating, a Copayment of $ [0-$30.00].]
[For Tinted Lenses, a Copayment of $ [0-$30.00].]
[For Polarized Lenses, a Copayment of $ [0-$20.00].]
[For High Index Lenses, a Copayment of $ [0-$30.00].]

The above bracketed language will be included if policyholder purchases lens option coverage. Language will vary depending on what option(s) are purchased by policyholder.

5. Page 4,

[Frames*

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the purchase of one set of frames. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-$30.00]† 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. For a list of non-covered materials, please refer to the section entitled "Plan Limitations".

Your Plan Benefits for frames and lenses shall also include necessary professional services such as prescribing and ordering proper lenses, assisting in frame selection, verifying accuracy of finished lenses, proper fitting and adjustments of frames, subsequent adjustments to frames to maintain comfort and efficiency and progress or follow-up work as necessary.

[Frame Allowance may be applied towards non-prescription sunglasses, exhausting both frame and lens eligibility. Lab-fabricated plano lenses are not covered.]

† If both frames and lenses are purchased separately during a single Plan Term, the $ [0-$30.00] Copayment will apply only to the first item purchased. If both frames and lenses are purchased together during a single Plan Term, only one $ [0-$30.00] Copayment will be required for the combined purchase.]

This language will be included when frames coverage is purchased by the policyholder. The language regarding sunglasses is also bracketed because a policyholder may purchase frame coverage without purchasing frame coverage for non-prescription sunglasses. The language regarding nonprescription sunglasses will only be included when such coverage is purchased by the insured.

6. Page 5,

[Contact Lenses*

Each Plan Term You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. An additional discount of fifteen percent (15%) will apply to the VSP Preferred Provider professional fee. For each pair of extended wear contact lenses or for each supply of disposable contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), any amounts which exceed Your Plan allowance, and 2), any charges for services and/or materials not covered under this Policy. For a list of non-covered services and materials, please refer to the section entitled "Plan Limitations".]

This language will be included when contact lens coverage is purchased by the policyholder.

7. Page 5,
[*Important: Under this Policy, [each Plan Term] You and each of Your Covered Dependents may purchase <u>either</u> 1) one pair of prescription eyeglasses (frame and lenses), <u>or 2),</u> one pair of extended wear contact lenses or a supply of disposable contact lenses.]

This language will be included when the insured purchases coverage with the option to use his or her allowance towards either contact lenses <u>or</u> eyeglasses.

8. Page 5,

[Contact Lens Fitting and Evaluation Exam

Each Plan Term, You and each of Your Covered Dependents are entitled to exam specific to contact lenses for fitting and evaluation. At the time of the examination, You will be responsible for paying the VSP Preferred Provider a Copayment of $ [0-$20.00]. You will not be responsible for any other charges relating to the examination.]

[SunCare Non-Prescription Frame Allowance

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-300.00] toward the purchase of one set of nonprescription sunglasses. For each set of frames You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-$30.00]† 2), any costs for the purchase of the frames which exceed Your plan allowance and 3), any charges for materials not covered under this Policy. Lab-fabricated plano lenses are not covered.]

[Second Pair

Each Plan Term, You and each of Your Covered Dependents are entitled to an allowance of $[95.00-$300.00] toward an additional pair of frames and prescription lenses or contact lenses subject to any conditions, limitations and/or exclusions stated in this Policy. For each additional pair of frames and prescription lenses or contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0-

$30.00][†] 2), any costs for the purchase which exceed Your plan allowance and 3), any charges for materials not covered under this Policy.

[Covered Contact Lenses

Each Plan Term You and each of Your Covered Dependents are entitled to an allowance of $ [95.00-$300.00] toward the cost of professional services and the purchase price of one pair of extended wear contact lenses or a supply of disposable contact lenses. An additional discount of fifteen percent (15%) will apply to the VSP Preferred Provider professional fee. For each pair of extended wear contact lenses or for each supply of disposable contact lenses You and Your Covered Dependents receive, You will be responsible for paying the VSP Preferred Provider 1), a Copayment of $ [0.00-$50.00] 2), any amounts which exceed Your Plan allowance, and 2), any charges for services and/or materials not covered under this Policy. For a list of non-covered services and materials, please refer to the section entitled "Plan Limitations".]

The above language will be inserted as appropriate to the plan benefits purchased by policyholder.

9. Page 6,

[OTHER PLAN BENEFITS

You and each of Your Covered Dependents are also entitled to receive the additional vision care services as stated below.

Additional Discount

In addition to the specific Plan Benefits stated above, You and each of Your Covered Dependents are entitled to receive a discount of twenty percent (20%) toward the purchase of <u>additional</u> complete pairs of prescription glasses (frames, lenses and Lens Options) from VSP Preferred Providers. Additional pairs are those purchased beyond the Plan Term benefit frequency allowed under this Policy.

Also, You and each of Your Covered Dependents are entitled to receive a discount of fifteen percent (15%) off of any VSP Preferred Provider's professional fees for evaluation and fitting of contact lenses.

You will be responsible for paying the VSP Preferred Provider the balance of any charges for materials and services after the applicable discount(s) are applied. To receive the discount(s), all services and/or materials must be purchased within twelve (12) months of an examination covered under this Policy and must be purchased from a VSP Preferred Provider.

Important: Additional Discounts do not apply to vision care services and/or materials obtained from an Open Access Provider.]

The above language will be included when the policyholder purchases coverage with eyeglasses and/or contact lens allowance.

10. Page 7,

	In-Network Schedule of Allowances	Open Access Schedule of Allowances
Service or Material		
[Examination	Covered in Full – Minus Copay	$ 45.00]
[Single Vision Lens (pair)	Covered in Full – Minus Copay	$ 30.00]
[Bifocal Lens (pair)		$ 50.00]
[Trifocal Lens (pair)		$ 65.00]
[Lenticular Lens (pair)		$ 100.00]
[Frame	Covered up to the Purchase Price of the frame, not to exceed $150.00	$ 70.00]
[Contact Lens (pair)	Covered up to the Purchase Price of the frame, not to exceed $150.00	$ 105.00]

The above language is bracketed because the services/materials included in the Open Access Schedule of Allowances will vary depending on the coverage purchased by the insured.

11. Copayment ranges and numeric amounts throughout all documents

    This information is bracketed because amounts may vary, in increments of $5.00.

PROTEC SAFETY (ProTec Rider DC 1119)

1. Page 2, [There shall be a $ [5.00-$25.00] Copayment payable at the time the materials are ordered. *Or* There shall be no Copayment payable by Covered Person under this plan.]

This language is bracketed because language will vary based on whether a copayment is applicable.